Report to the Social Services Appropriations Subcommittee

Increased Medicaid Program Efficiencies

December 24, 2012

UTAH DEPARTMENT OF HEALTH

Statutory Requirement

As first required by House Bill 459 (2010), the Utah Department of Health (Department) submits this response to comply with the following statutory requirement in UCA 26-18-2.3:

> *Division responsibilities -- Emphasis -- Periodic assessment.*
>
> *(4) The department shall ensure Medicaid program integrity by conducting internal audits of the Medicaid program for efficiencies, best practices, fraud, waste, abuse, and cost recovery.*
>
> *(5) The department shall, by December 31 of each year, report to the Health and Human Services Appropriations Subcommittee regarding:*
>
> *(a) measures taken under this section to increase:*
>
> *(i) efficiencies within the program; and*
>
> *(ii) cost avoidance and cost recovery efforts in the program; and*
>
> *(b) results of program integrity efforts under Subsection (4).*

Increased Medicaid Efficiencies

Over the past year, the Division of Medicaid and Health Financing (Division) within the Department has implemented many changes to improve the efficiency and effectiveness of the areas of the Medicaid program it manages. In addition to the efficiencies it has identified on its own, the Division has also worked with many partners (including legislative auditors, its legislative fiscal analyst, and the federal government) to identify other potential improvements and then implement those changes. Some of these efficiencies have produced budget savings, others have resulted in cost avoidance, and others have created improved operating processes for the Medicaid program.

Accountable Care Organizations

On June 30, 2011, the Division submitted an 1115 Waiver Request to the federal government to transform the way Utah operates its Medicaid program in the four Wasatch Front counties (Salt Lake, Weber, Davis and Utah). Through the waiver, the Division attempted to slow the growth of Medicaid costs while preserving the quality of care provided to clients. Three of the request's major goals are to:

- Restructure the program's provider payments to reward health care providers for delivering the most appropriate services at the lowest cost and in ways that maintain or improve recipient health status.
- Pay providers for episodes of care rather than for each service.

- Restructure the program's cost sharing provisions and other incentives to reward recipients for personal efforts to maintain or improve their health and use providers who deliver appropriate services at the lowest cost.

The proposal would replace the current Utah Medicaid fee-for-service/managed care model with the Utah Medicaid Accountable Care Organization (ACO) model along the Wasatch Front. The new contracts would essentially provide the ACOs with monthly risk-adjusted, capitated payments based on enrollment. The ACOs would then create an environment in which they deliver necessary and appropriate care, while demonstrating that quality of care and access to care are maintained or improved.

The ACOs would also have more flexibility to distribute payments to their network of providers. Rather than reimbursing providers based on the units of service delivered, the ACO could make payments for delivering the necessary care to a group of Medicaid enrollees for a specified period of time. The ACO could also choose to distribute incentive payments through its network of providers when various cost-containment, quality or other goals are met.

Unfortunately, the federal government denied three of the five changes sought in the State's waiver request:

- Allow the State to charge slightly higher copays for some services (e.g., charging $5 for physician visits and $25 for an emergency department visit) – **DENIED** [Requires change in federal law or change in CMS interpretation of federal law]
- Allow the State to use a prioritized list of services when implementing cuts during budget shortfalls (i.e., the lowest priority services would be cut first). This request was modeled after the approved practice in Oregon's Medicaid. – **DENIED**
- Allow clients to have the option to receive premium assistance for enrolling in their employer's health plan (or COBRA plan) rather than receiving direct coverage through Medicaid – **DENIED**
- Allow the State to encourage plans to change their reimbursement to providers away from the traditional fee-for-service arrangement – **APPROVED**
- Allow the ACOs to offer incentives to clients when the clients complete certain healthy behavior activities – Originally **DENIED** then **APPROVED**

Despite the denial of several requests, the Division has worked to implement the requests that were approved. On January 1, 2013, Medicaid clients in Weber, Davis, Salt Lake, and Utah counties will begin receiving services through an ACO. By moving health plans to capitated payments and enhancing quality measures in their contracts, it is expected that the change will increase the effectiveness and efficiency of the Medicaid program in these counties.

Emergency Dental Services

Due to budget cuts in previous years, non-pregnant adults on Medicaid have had no dental coverage. Many Medicaid clients seek emergency dental services in Utah's emergency rooms due to a lack of coverage in more appropriate settings. However, emergency rooms are an expensive source of treatment for Medicaid clients to find relief from tooth pain.

With the support of legislative intent language, Medicaid notified providers that the following limited Emergency Dental Services would be available to non-pregnant adults beginning July 1, 2012:

- A limited oral evaluation;
- Dental x-ray, first film;
- Dental x-ray, each additional film, if needed;
- Tooth extraction;
- Surgical tooth extraction; and
- Incision and drainage of abscess

Between July 1, 2012 and the end of November 2012, Medicaid received and paid 849 emergency dental claims under the new Emergency Dental Services program. These claims totaled $104,035 in provider reimbursement, for an average of $122.54 per visit.

By comparison, hospital emergency department visits for acute dental services averaged $987.61 for the same period of time.

The Medicaid Emergency Dental Services program has provided better access to a more appropriate care setting and is a less costly alternative to emergency department visits. Assuming all of these clients would have received care in an emergency department, the total estimated savings for the first five months of the program are $734,444.

Prepayment Edits

In FY 2011, the Division implemented an additional prepayment editing tool through a contract with Bloodhound Incorporated (now Verisk). The editing tool was an enhancement to the existing rules within the Medicaid Management Information System (MMIS) that detect errors in Medicaid provider billing.

Bloodhound's ConVergence Point product incorporates correct coding principles and industry accepted standards and guidelines to identify appropriate coding for provider billing and reimbursement. The ConVergence Point product edits Medicaid's Professional and Outpatient Facility claims on a weekly basis, prior to final adjudication. With this additional computer support, claim edits are applied more consistently. Some individualized customization to the product has been built into the tool to more fully support Medicaid policy.

Implementation of the tool has resulted in more appropriate payment for services. Since December 2010, the Division has realized over $5.1 million in reduced Medicaid payments from this tool.

Pay for Performance

In FY 2012, the Division implemented a Pay for Performance Pilot in its Provider Enrollment Unit, which processes applications from doctors and other medical providers that want to treat Medicaid clients. The unit checks the applicant information against federal exclusion databases and then enrolls eligible providers in the program. The Pay for Performance Pilot rewards staff when they complete a high volume of work while still maintaining a high level of quality. Pilot incentive awards are paid out once a month. The maximum earning potential per employee/per calendar year is $8,000 (per state policy).

Before the pilot began, the Provider Enrollment Unit had six staff who processed approximately 275 regular applications per month on average. As a result of the efficiencies obtained through this pilot, the Division was able to redirect one of the six staff to another area. In a recent month, the unit was able to process 592 regular applications with just five staff.

This jump in productivity has had a positive impact for providers as well. Before the pilot, it often took four to six weeks before a provider's application was processed. Now these applications are processed within a week, often within several days.

Due to the success of the Provider Enrollment Pilot, the Division has started a second pilot with its Medical Review Board Unit. This unit processes applications from individuals that are seeking a disability determination from Medicaid (often while they are waiting for a disability determination from Medicare). Initial experience with the Medicaid Review Board Pilot has shown an increase in the number of applications being processed by the unit. The pilot is still being fine tuned to make sure it appropriately matches bonuses with high volume/high quality work.

Ongoing Efficiency Efforts

The Department also has several ongoing projects that have generated increased savings and efficiencies for the Medicaid program this year.

- Each year the Division works with its Pharmacy and Therapeutics (P&T) Committee to determine if additional drug classes should be added to Medicaid's Preferred Drug List (PDL). In FY 2012, the Division added 18 new drug classes to the PDL. As a result of the Division's use of the PDL, Medicaid saved $34 million in FY 2012.
- In FY 2012, the New Choices Waiver program added 158 new enrollees over its FY 2011 enrollment. Each waiver enrollee is someone who was previously receiving care in a nursing home and now receives services in a less costly environment (often an assisted living facility).

The average cost savings per person in this waiver is approximately $15,200 per year. Medicaid cost avoidance this year due to the increased waiver enrollment is $2.4 million in total funds.

- The Division continues to operate a "Lock In" program for Medicaid clients who demonstrate a pattern of excessive program utilization. The Division restricts these clients to one pharmacy and one prescribing provider. In 2012, the Division conducted case reviews on 2,098 individuals. There are currently 677 individuals in the "Lock In" program as a result of Medicaid benefit misuse or abuse.
- The Division operates an Emergency Department Diversion program to redirect clients seeking primary care needs in the Emergency Department of the State's hospitals. Once a client registers an Emergency Department visit with a non-emergent diagnosis on the claim, the Division will contact that individual and help him or her find a primary care provider and educate the client on when Emergency Department utilization is appropriate. In 2012, the Division sent 16,563 education letters and provided one-on-one education to 1,920 individuals. An additional 336 individuals are in the "Lock In" program as a result of Emergency Department Diversion efforts.

Internal Audits of the Medicaid Program

The Office of Inspector General for Medicaid Services (OIG) was created in July 2011. Many audit positions related to Medicaid were moved from the Department to the OIG to staff that office. As a result, among other responsibilities, the OIG is to audit, inspect, and evaluate the functioning of the Division to ensure that the Medicaid program is managed in the most efficient and cost-effective manner possible. The OIG is directed to issue its own reports to the Legislature on its efforts.

Despite the loss of staff in 2011, the Department has continued to operate its own Office of Internal Audit (OIA). Responsibilities for the OIA are broader than just Medicaid and include performing internal audits and reviewing grants issued by the Department.

The OIA had two direct audits of Medicaid to identify and resolve fraud, waste and abuse. The first audit focused on the claims cycle for Nursing Homes and the second audit focused on providers' billing of evaluation and management (E&M) codes.

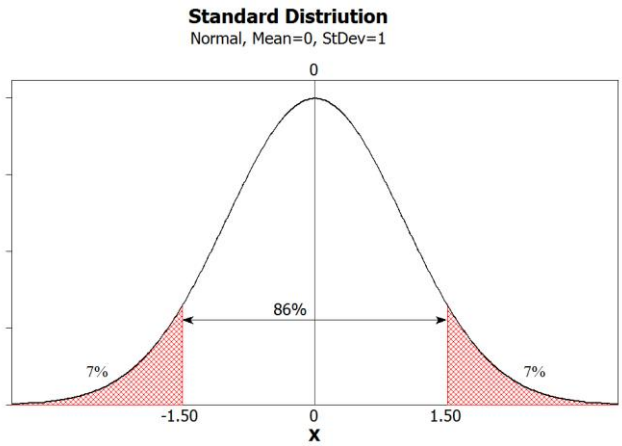
The Nursing Home audit report was issued on June 15, 2012. The life cycle of Nursing Home claims was reviewed. The purpose was to evaluate the adequacy of policies, procedures, and internal controls within the Utah Medicaid Nursing Home Program and to make recommendations regarding potential efficiencies. The OIA compared all (323) approved daily nursing home rates for Calendar Year (CY) 2011 developed by the Division's Bureau of Coverage and Reimbursement Policy with the master file to ensure rates were correctly posted. OIA then compared all (over 100,000) reimbursed nursing home claims for CY 2011 with authorized daily rate amounts.

The Medicaid E&M code analysis report was issued on August 21, 2012. The purpose of the review was to analyze Medicaid billing patterns to identify providers who have excessively high billing patterns. The

review covered claims with date of service during the period July 1, 2010, through June 30, 2012. A total of 2,374 providers with 1 million E&M claims were analyzed. Providers were compared with other providers having a similar provider type and specialty code. Providers that billed 1.75 standard deviations or more above the mean for their provider type were submitted to OIG for review of medical charts to determine appropriateness of coding. A total of 65 providers were submitted to OIG. Providers that billed between 1.5 and 1.75 standard deviations above the mean for their provider type were sent a letter indicating how they bill compared with the average billing pattern. The letter indicates that we will monitor billing patterns going forward. A total of 45 providers were sent a letter. Graphs and charts below are provided to assist the reader in understanding the nature of the work.

The table and chart below shows coverage in terms of a standard deviation measurement of a normal distribution:

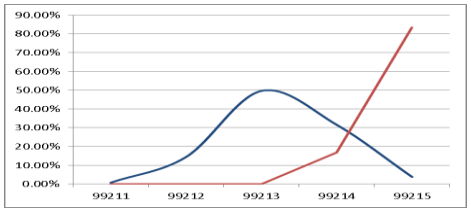
Standard Deviation From Average	Population Coverage
1.0	68%
1.5	86%
2.0	95%
3.0	99.7%



Provider Type: Group Practice

Category of Service: Vision Care

CPT Code	Medicaid Claims Population	Medicaid Average Billing	Your Claims	Your Average Billing	Difference from Medicaid	# Std. Dev.
99211	34	0.75%	0	0.00%	-0.75%	(0.20)
99212	649	14.40%	0	0.00%	-14.40%	(0.73)
99213	2234	49.56%	0	0.00%	-49.56%	(1.38)
99214	1421	31.52%	29	16.67%	-14.86%	(0.22)
99215	170	3.77%	145	83.33%	79.56%	6.73
	4,508	100.00%	174	100.00%		

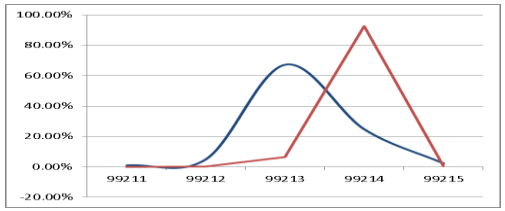


(Provider 6.7 standard deviations above average)

Provider Type: Group Practice

Category of Service: Specialized Nursing

CPT Code	Medicaid Claims Population	Medicaid Average Billing	Your Claims	Your Average Billing	Difference from Medicaid	# Std. Dev.
99211	228	0.94%	0	0.00%	-0.94%	(0.19)
99212	1215	5.00%	1	0.28%	-4.72%	(0.40)
99213	16326	67.23%	23	6.52%	-60.72%	(1.28)
99214	5980	24.63%	327	92.63%	68.01%	1.75
99215	533	2.20%	2	0.57%	-1.63%	(0.31)
	24,282	100.00%	353	100.00%		

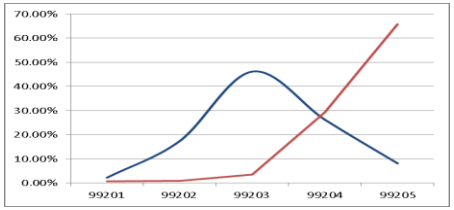


(Provider 1.75 standard deviations above average)

Provider Type: Group Practice

Category of Service: Physician Services

CPT Code	Medicaid Claims Population	Medicaid Average Billing	Your Claims	Your Average Billing	Difference from Medicaid	# Std. Dev.
99201	1961	2.21%	2	0.63%	-1.58%	(0.16)
99202	15440	17.37%	3	0.94%	-16.43%	(0.57)
99203	41012	46.14%	11	3.46%	-42.68%	(0.99)
99204	23275	26.18%	93	29.25%	3.06%	(0.06)
99205	7203	8.10%	209	65.72%	57.62%	2.00
	88,891	100.00%	318	100.00%		

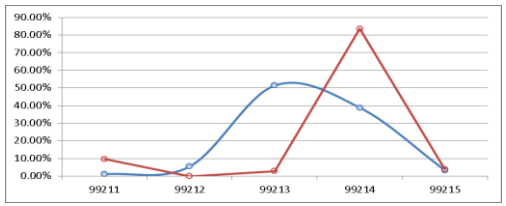


(Provider 2.0 standard deviations above average)

Provider Type: Group Practice

Category of Service: Physician Services

CPT Code	Medicaid Claims Population	Medicaid Average Billing	Your Claims	Your Average Billing	Difference from Medicaid	# Std. Dev.
99211	8789	1.07%	45	9.72%	8.65%	1.29
99212	44796	5.43%	0	0.00%	-5.43%	(0.53)
99213	423662	51.38%	13	2.81%	-48.58%	(1.34)
99214	320113	38.82%	387	83.59%	44.76%	1.53
99215	27143	3.29%	18	3.89%	0.60%	(0.15)
	824,503	100.00%	463	100.00%		



(Provider 1.5 standard deviations above average)

OIA performed audits and provided services that affected Medicaid in an indirect manner.

OIA performed a cash audit of the three dental clinics and three medical clinics run by the Department of Health. These facilities are subsidized by Medicaid. The cash audits included cash collected at the front office and cash payments received by mail.

OIA performed six provider audits of the vaccines for children (VFC) program. This program is paid with Medicaid funds. These audits review controls of providers who administer vaccines to children designated as low-income.

OIA loaned a staff member to the Department full-time for three months to provide technical assistance to improve the I.T. security for "covered entities" (a HIPAA term designating organizations that must keep information secure as they retain protected health information). This staff member will continue to be on loan for the first three months of calendar year 2013. Duties focused on Medicaid and areas of Department that support Medicaid.

Two members of our staff performed Medicaid Cost Reviews for six months. These reviews determine various providers' Medicaid costs to ensure provider costs are valid per federal regulations (Pub. 15). Providers reviewed include nursing homes, private hospitals, state hospital, and mental health providers.

Conclusion

The Department is committed to continually improving the Medicaid program. It is the Department's goal to employ healthcare delivery and payment reforms that improve the health of Medicaid clients while keeping expenditure growth at a sustainable level. The Department will maintain previously identified efforts to improve efficiency as they continue to save the State tens of millions of dollars each year. In addition, the Department will continue to seek out the most effective way to carry out its responsibilities in the future.